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No. 03-1339

Supreme Court, U.S.
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IN THE

Supreme Court of the United States

THE UNIVERSITY OF MEDICINE AND DENTISTRY OF NEW JERSEY, and UNIVERSITY PHYSICIAN ASSOCIATES OF NEW JERSEY,

Petitioners,

v.

DARA CORRIGAN, Acting Inspector General, United States Department of Health and Human Services,

Respondent.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE THIRD CIRCUIT

REPLY BRIEF

KEVIN MCNULTY
GIBBONS, DEL DEO, DOLAN, GRIFFINGER & VECCHIONE, P.C.
ONE RIVERFRONT PLAZA
NEWARK, NJ 07102
(973) 596-4873

MAUREEN E. MAHONEY
J. SCOTT BALLENGER
LATHAM & WATKINS LLP
555 11TH ST., N.W. SUITE 1000
WASHINGTON, DC 20003
(202) 637-2200

HERVÉ GOURAIGE
Counsel of Record
JEREMY ESAKOFF
JESSICA A. PLATT
EPSTEIN BECKER & GREEN, P.C
TWO GATEWAY CENTER, 12 FLOOR
NEWARK, NJ 07102
(973) 642-1900

Counsel for Petitioners

187800

COUNSEL PRESS
(800) 274-3321 • (800) 359-6859

RULE 29.6 STATEMENT

Petitioners' corporate disclosure statement was set forth at page *ii* of the Petition for a Writ of Certiorari, and there are no amendments to that statement.

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REPLY TO BRIEF IN OPPOSITION

Pursuant to Supreme Court Rule 15.6, Petitioners reply to the following new points raised in the Brief for the Respondent in Opposition ("Opp. Br.").

1. Respondent's Opposition is based on the false premise that the Inspector General ("IG") of the Department of Health and Human Services ("HHS") is conducting an "audit or investigation of potential fraud or abuse" of Petitioners as recipients of Medicare funds. (Opp. Br. at 14). Before the litigation, and Petitioners' challenge to the HHS-IG's authority to conduct routine compliance audits, the IG made it clear that the nationwide audits of all academic medical centers were aimed at "*compliance* with Intermediary Letter 372 [teaching physician billing regulation]." Verified Cplt., Exh. P at 1 (C.A.A. 183) (emphasis added). Also before the litigation, the IG informed Petitioners that she did not suspect fraud by their teaching physicians. *Id.* at ¶ 73 (C.A.A. 67). After this challenge to the IG's authority to conduct routine compliance audits commenced, the IG began describing her audit as an alleged fraud investigation in an attempt to create authority where plainly none exists. This is an implicit concession that the IG lacks authority to do compliance audits and must refashion the audit as a fraud investigation to support her assertion of authority.

2. The only section of the IG Act of 1978 upon which Respondent relies does not support her position. Under the Inspector General Act of 1978, 5 U.S.C.A. app. 3 § 6(a)(2), the IG has broad discretion to "make . . . investigations and reports relating to the administration of the programs and operations of [HHS]." The authority granted here is to make investigations for the purpose of submitting reports to the

Secretary and Congress about the operations of the department. The authority granted by § 6(a)(2) is the same as was granted by § 204(d)(A) of the previous IG Act of 1976, which detailed the procedure, timing, and content of the HHS-IG's reports to Congress and the Secretary. Pub. L. 94-505, Title II, 90 Stat. 2431-32 (1976). This case is not about the IG's authority to conduct investigations for the purpose of making reports to the Secretary and the Congress regarding the operations of the Medicare program.

3. This case is instead about the IG usurping the authority specifically granted by Congress to the local Medicare carriers to conduct routine compliance audits. 42 U.S.C. § 1395(u)(a)(1)(A)(C). This specific grant of authority to the carriers trumps the generic language, upon which Respondent relies, of the IG Act of 1978 to "conduct, supervise, and coordinate audits and investigations relating to [HHS] programs." (Opp. Br. at 4). Significantly, the Respondent's Opposition fails to address the Petitioners' central argument on this issue, namely, the specific statutory delegation by Congress of the audit compliance function to the carriers.

4. Respondent makes the highly formalistic argument that *Burlington Northern R.R. v. Office of Inspector General, R.R. Ret. Bd.*, 983 F.2d 631 (5th Cir. 1993) is inapposite because the Centers for Medicare and Medicaid Services ("CMS") and its local carriers have not expressly and formally transferred the authority delegated to them by Congress to the IG, in contravention of Section 9(a)(2) of the IG Act of 1978. (Opp. Br. at 14). That argument is beside the point. The IG may not conduct routine compliance audits because, as the D.C. Circuit and the Fifth Circuit have recognized, such audits do not fall within the authority

granted to IGs by Sections 4 and 6 of the IG Act. To ensure that the limitation is respected, Section 9(a)(2) of the IG Act also prohibits the agency from transferring *its own* routine compliance authority to the IG. The statute therefore prohibits an IG from assuming routine compliance functions even if the agency wanted the IG to do so. The fact that the IG in this case has de facto usurped that function without even the fig leaf of a "transfer" of authority from the agency makes that usurpation worse, not better.

5. Petitioners, recipients of Medicare funds, do not argue that they cannot be audited for routine compliance or for fraud. Instead, this dispute is about which federal agency has the statutory authority to audit Petitioners for compliance. Congress has directed the Secretary to make the Medicare carriers the exclusive agents to perform routine compliance audits and has restricted the IG of HHS to "auditing and investigating [HHS]," *United States Dep't of Justice v. Federal Labor Relations Auth.*, 39 F.3d 361, 368 (D.C. Cir. 1994), and to conducting fraud investigations. "Congress intended the Inspector General to be an objective official free from general regulatory responsibilities who investigated the employees and operations of the Department, as well as its contractors, grantees and other recipients of federal funds, so as to root out waste and fraud." Authority of the Inspector General to Conduct Regulatory Investigations (Preliminary Opinion), 13 Op. O.L.C. 63, 1989 OLC LEXIS 4 (March 9, 1989).

6. The 1989 Opinion of the Office of Legal Counsel recognizes the authority of an IG to investigate recipients of Federal funds for fraud. *Id.* at *17. Petitioners make no challenge to that authority. Nor do Petitioners challenge the authority of the federal government to conduct routine

compliance audits of their Medicare operations. But these distinct functions have been assigned by Congress to two different agencies: the IG has authority to investigate recipients of Medicare funds for fraud, while the Medicare carriers have the exclusive authority to conduct routine compliance audits.

7. Even assuming that resort to legislative history is appropriate here when the statutory language and the structure established by Congress are clear, *Household Credit Servs., Inc. v. Pfenning*, 124 S. Ct. 1741, 1746-47 (2004), the legislative history cited by Respondent merely confirms that Congress intended the IG of HHS to conduct fraud investigations. (Opp. Br. at 12-13) (noting Senate Report commendation of HHS-IG for spearheading "'nationwide effort to deal systematically with Medicaid *fraud*'") (emphasis added). Respondent does not cite to any reference in that legislative history mentioning the conduct of routine compliance audits by the IG.

8. Respondent's attempt to distinguish *Burlington Northern*, 983 F.2d 631 (5th Cir. 1993) and *Truckers United for Safety v. Mead*, 251 F.3d 183 (D.C. Cir. 2001) is unpersuasive. Respondent argues that *Burlington Northern* is unlike this case because there the agency "never exercised its statutory duty," (Opp. Br. at 13), while here the carriers "continue to have *primary* responsibility for ensuring that Medicare providers are entitled to the reimbursement they claim." (*Id.* at 14) (emphasis added). But Congress did not grant concurrent authority to the IG and the carriers to perform that function; it granted exclusive authority to the carriers.

9. Respondent's effort at distinguishing *Truckers United* is even less convincing. According to Respondent, "*Truckers United* has no application to the investigation of fraud and abuse by recipients of federal Medicare funds." *Ibid.* (footnote omitted). But, as demonstrated above, the IG's own language, before the challenge to her authority, characterized the PATH audits, specifically as they pertained to Petitioners, as compliance efforts, not fraud investigations. That this case involves recipients of federal funds while *Truckers United* did not is not a fact relevant to the rationale of that decision. There, the Court of Appeals held the IG's effort "to determine whether individual trucking companies were *complying* with federal motor carrier safety regulations," 251 F.3d at 187 (emphasis added), was *ultra vires* and unauthorized by the IG Act of 1978. The IG was not attempting to *enforce* the regulatory safety regulations against members of the public; he sought to assist the regulatory agency in auditing whether the public was complying with them. *Id.* at 184 ("the Office of Motor Carriers . . . initiated compliance review investigations into appellants' record keeping practices [and sought the IG's assistance] to obtain appellants' business records"). The D.C. Circuit's ruling that such actions are prohibited by the IG Act of 1978 applies with at least equal force to the IG's unilateral effort in this case to audit Petitioners' compliance with a Medicare billing regulation. There is nothing in the language of the IG Act of 1978 or its structure to suggest a different ruling in the case of recipients of federal funds. Indeed, the specific grant of congressional authority to the carriers to perform the compliance function makes this case an even stronger one for denying the IG the authority to do compliance audits.[1] And while the 1989

1. In *Truckers United*, the Court of Appeals specifically rejected the argument, advanced by Respondent (Opp. Br. at 14 n.2), that the 1999 legislation cited by Respondent that specifically granted

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OLC opinion noted that it was not analyzing a situation involving the recipients of federal funds, it did clearly reject the suggestion, made by the HHS-OIG at the time, that HHS was somehow exempt from the basic "separation of powers" principles embodied in the IG Act. *See* OLC op. at *16 n.13. Respondents' interpretation of the Act would entirely nullify the distinction between the IG and the agency itself for all of the many federal programs (Medicare, Medicaid, Social Security, etc.) that exist principally to distribute federal funds. That is plainly not what Congress intended.

10. While not central to Petitioners' challenge to the IG's statutory authority to do routine compliance audits, certain aspects of Respondent's statement of facts require correction. Whether or not the "'overwhelming majority' of regional carriers had consistently read [the regulatory language] to require the attending physician's physical presence when a resident performed a service'" (Opp. Br. at 5)—a doubtful proposition[2]—the evidence is uncontradicted in this case that Petitioners' carrier did not communicate that to them as the billing standard.

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additional authority only to the IG of the Department of Transportation ("DOT") repudiated the *Burlington Northern* doctrine and retroactively authorized the 1998 IG compliance audits undertaken by the IG of DOT. While the Court of Appeals "declined to address whether the DOT IG could, in the future, undertake similar investigations in light of this new statutory authority," (Opp. Br. at 14-15 n.2), it reversed the district court on the issue of retroactive authorization argued by Respondent here. 251 F.3d at 191-92.

2. The PATH Overview cited by Respondent refers to 6 of the 25 Medicare Part B carriers in existence in 1996 as having such a clear standard (C.A.A. 320-21). *See Medicare & Medicaid Guide* (CCH) § 44, 641 (listing number of Medicare carriers in 1996). Twenty-four (24) percent is hardly an "overwhelming majority."

11. The Medicare carrier guidance that Respondent relies upon to establish Petitioners' knowledge of the standard the OIG wishes to employ in the audits was issued by the Pennsylvania carrier and not that for New Jersey. After the Pennsylvania carrier also became the New Jersey carrier on January 1, 1989, the publication was not reissued to New Jersey providers such as Petitioners. The IG determination of notice to Petitioners is based upon decennial indices put out by the carrier in 1989 and 1990 (after its territory was expanded to include New Jersey) that contains a listing (in single-spaced, double columns) of all publications put out over the period 1980-90, including the carrier guidance first published in 1982 to non-New Jersey providers that had not been re-sent to the New Jersey providers such as Petitioners after 1989. (C.A.A. at 256-67, 288-98, and 302-07).

12. Even if Petitioners' carrier had communicated that standard, the fact, conceded by Respondent (Opp. Br. at 3 and n.1) and the Court of Appeals (Cert. Pet. App. 8a), that the Secretary's regulation did not contain the requirement that residents treat patients "in the presence of a teaching physician" would have entitled Petitioners to bill in compliance with the Secretary's regulation, and not follow the carrier's stricter interpretation. While carriers, as noted above, are authorized by Congress to conduct compliance audits, only the Secretary is vested by Congress with authority to promulgate and interpret substantive Medicare regulations. 42 U.S.C. § 1395(g) (West Supp. 2002). In billing Medicare, Petitioners properly complied with the Secretary's then-existing regulation and their carrier's interpretation.

13. Respondent's implied charge of bad faith by Petitioners is unwarranted. (Opp. Br. at 7). Petitioners originally agreed to employ an independent auditor to do a PATH audit upon the expressed understanding that the OIG would utilize the billing standard in the Secretary's regulation and communicated to them by their carrier, and that they understood to be in effect when they submitted their bills. Petitioners expressly reserved their right to withdraw from the self-audit and challenge any aspect of it. (C.A.A. 538-40). When the IG refused to apply what Petitioners maintain is the correct standard, and directed the independent auditor to use a different standard (C.A.A. 539-40), Petitioners sued to enjoin the audit.

14. This case does not involve a "risk that Medicare providers will bill the program twice for the same services." (Opp. Br. at 2). Under Part A of the Medicare program, hospitals submit annual costs reports listing their costs of goods and services and Medicare reimburses them the allowable costs for such goods and services, including the direct costs of residents in training ("GME") and the indirect costs associated with having residency teaching programs ("IME"). 42 C.F.R. 412, 413.86. Separately, under Part B of Medicare, physicians who practice at such hospitals and teach in the approved residency programs may bill Medicare for *their* services to Medicare patients in such hospitals. 42 C.F.R. 414, 415. The GME and IME reimbursements by Medicare to hospitals are distinct and separate from reimbursements to teaching physicians for *their* services to patients. *Compare* 42 C.F.R. 412, 413.86 *with* 42 C.F.R. 414, 415. If teaching physicians are employees of the hospital and assign to the hospital their right to bill for their services for Medicare patients, the hospital will be reimbursed the Part B payment that would otherwise be made to the

physician. Otherwise, hospitals do not bill, and are not reimbursed by Medicare, for the services of their teaching physicians; teaching physicians do not bill, and are not reimbursed, for GME and IME costs.

CONCLUSION

For the foregoing reasons, the petition for a writ of certiorari should be granted.

Respectfully submitted,

KEVIN MCNULTY
GIBBONS, DEL DEO, DOLAN,
GRIFFINGER & VECCHIONE, P.C.
ONE RIVERFRONT PLAZA
NEWARK, NJ 07102
(973) 596-4873

MAUREEN E. MAHONEY
J. SCOTT BALLENGER
LATHAM & WATKINS LLP
555 11TH ST., N.W. SUITE 1000
WASHINGTON, DC 20003
(202) 637-2200

HERVÉ GOURAIGE
Counsel of Record
JEREMY ESAKOFF
JESSICA A. PLATT
EPSTEIN BECKER & GREEN, P.C
TWO GATEWAY CENTER
12 FLOOR
NEWARK, NJ 07102
(973) 642-1900

Counsel for Petitioners